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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09691

## CERTIFICATE OF DEATH

09690

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Caroline MARYLAND		Maryland Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgeley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgeley	
c. LENGTH OF STAY IN 1b 20 Yrs.		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Saint Gertrudes Convent		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sr. M. Mechtilde		First	Middle
		Betz	Last
4. DATE OF DEATH		Month	Day Year
5. SEX Female		7	15 19 66
6. COLOR OR RACE White		8. DATE OF BIRTH	9. AGE (In years last birthday)
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		1-4-1903	63 yrs.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Work		11. BIRTHPLACE (County & State, or foreign country) Bavaria	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franz Betz		14. MOTHER'S MAIDEN NAME Frances Kornprobst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address Convent Records Ridgeley, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		48 hrs	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Hypertensive cerebral hemorrhage 48 hrs
		DUE TO (c)	Cerebrovascular Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> p.m. Not While at work <input type="checkbox"/>		20d. INJURY OCCURRED 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1966 to July 16, 1966, that (I) (we) last saw the deceased alive on July 16, 1966 and that death occurred at Ridgeley, Maryland, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott MD		22d. ADDRESS Ridgeley, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-18-66	
23c. NAME OF CEMETERY OR CREMATORIAL St. Gertrudes		23d. LOCATION (City, town or county) (State) Ridgeley, Maryland	
24. FUNERAL DIRECTOR J. E. Boulaire Greensboro, Md.		ADDRESS	
25a. REC'D BY REGISTRAR JUL 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09692

09691

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Henry</b>	Last Burrows
4. DATE OF DEATH	Month <b>July</b>	Day <b>26</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1897</b>
9. AGE (In years last birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Talbot Co., Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William J. Burrows</b>	14. MOTHER'S MAIDEN NAME <b>Catherine Councell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW I</b>	17. INFORMANT <b>Manie E. Burrows, Preston, Md., RFD</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>			
4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Sclerosis</b>			
25 yrs			
(c) <b>Generalized Arteriosclerosis</b>			
30 yrs			
INTERVAL BETWEEN ONSET AND DEATH <b>20 minute</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/8/40</b> , 19 to <b>7/26/66</b> , 19, that (I) (we) last saw the deceased alive on <b>7/26/66</b> , 19, and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>July 27, 1966</b>	
22a. SIGNATURE <i>Harold B. Plummer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Preston, Maryland</b>
22c. PHYSICIAN'S NAME (Type) <b>Harold B. Plummer, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 29, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Spring Hill Cemetery</b>
23d. LOCATION (City, town or county) <b>Easton, Maryland</b>		(State)	
24. FUNERAL DIRECTOR <b>J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE <b>JUL 28 1966</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09693

## CERTIFICATE OF DEATH

09692

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural</b>		c. LENGTH OF STAY IN 1b <b>full life</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>none</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithville near Federalsburg, Md.</b>				
3. NAME OF DECEASED (Type or print) <b>Clarence Theodore Hignutt</b>		d. STREET ADDRESS <b>05-1</b>				
4. DATE OF DEATH <b>July 26, 1966</b>	Month <b>19</b>	Day <b>1</b>	Year <b>1966</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 4, 1904</b>			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>61 yrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>grocery store operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Belle Hignutt</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-10-9197-A</b>	17. INFORMANT <b>Mrs. Mattie Hignutt Federalsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease,</b>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour a.m. <b>—</b> 19 p.m. <b>—</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that (I) (this hospital) attended the deceased from <b>May 2</b> to <b>July 20</b> , 1966, that (II) (we) last saw the deceased alive on <b>July 20</b> , 1966, and that death occurred <b>July 20</b> , 1966, M, from the causes and on the date stated above.						
22e. SIGNATURE <b>Philip P. Felipe</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip P. Felipe, M. D.</b>		22d. ADDRESS <b>Denton, Md 21625</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>7-29-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Bloomery Cem.</b>	23d. LOCATION (City, town or county) <b>Federalsburg rural</b>	(State) <b>—</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stanley W. Williams</b>		25a. REC'D BY REGISTRAR <b>AUG 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
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11/15/51

large stand of trees small greenish 20-25 ft tall

soil - 3 ft of sandstone

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FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**09694** **09693**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
<b>Caroline</b> MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>State Road Route 312</b>		e. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Robert Kenton</b>		First <b>Charles</b> Middle <b>Robert</b> Last <b>Kenton</b>	4. DATE OF DEATH <b>7 13 1966</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Stanley Kenton</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mary Kenton</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY <b>Fracture of the cervical spine with severance of the cord</b> IMMEDIATE CAUSE (a) <b>8244</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH instant	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20c. TIME OF INJURY Month Day Year Hour a.m. <b>7</b> <b>13</b> <b>66</b> p.m. <b>72</b> <b>36</b> <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Automobile accident in which he was thrown from car by hot driver</b>	
20d. INJURY OCCURRED <b>While at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Greensboro</b>	
20f. (City or town) <b>Ridgeley</b> (County) <b>Mary</b> (State) <b>Pa</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Jerry Blumer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Harold R. Plummer</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Greensboro</b>		23d. LOCATION (City, town or county) <b>Greensboro, Maryland</b> (State) <b>7-13-66</b>	
24. FUNERAL DIRECTOR <b>J. E. Boelaars Greensboro, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE	
VR AISM (5) 5M 1/65		DATE <b>JUL 18 1966</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

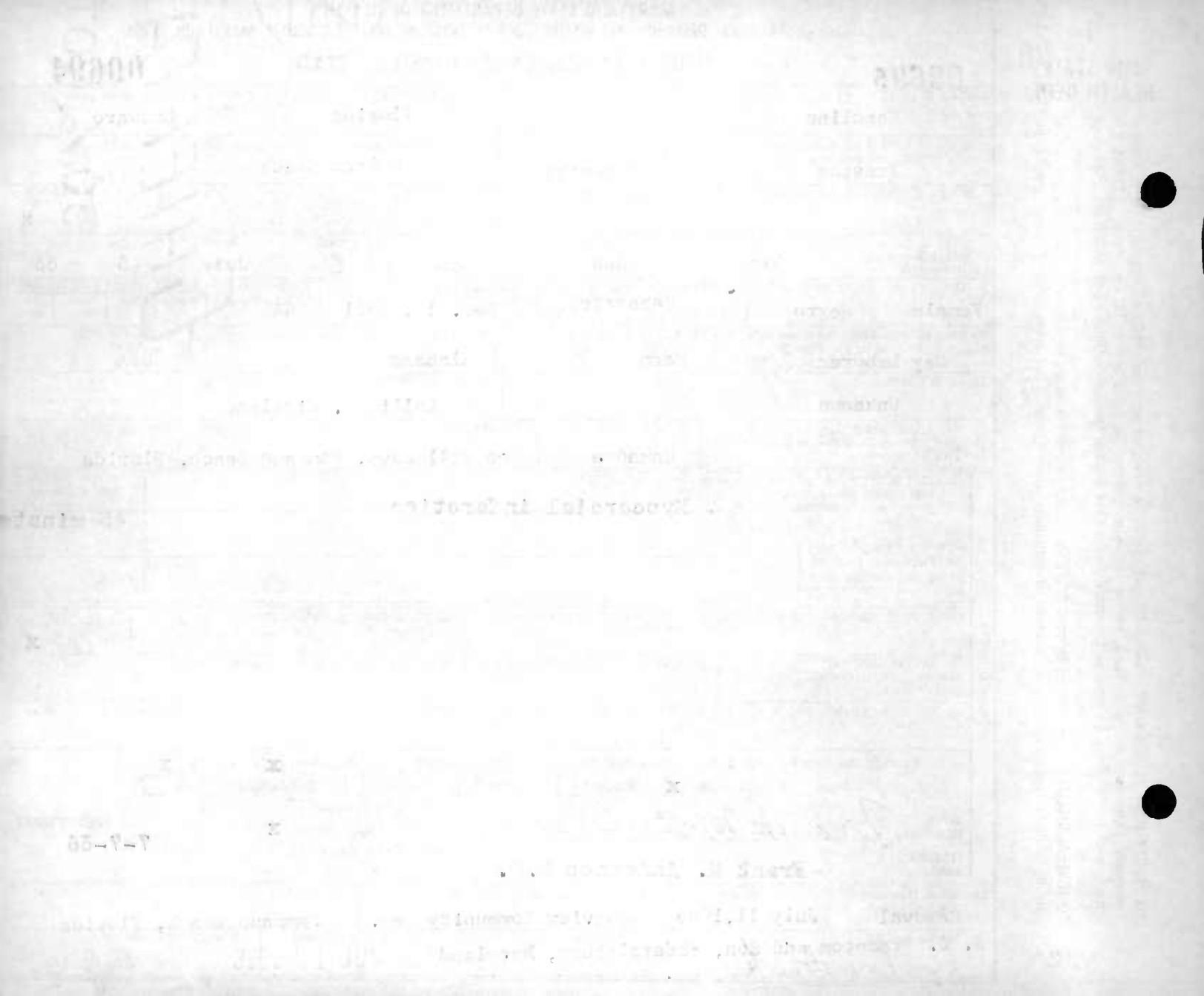
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09694

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Broward</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>		c. LENGTH OF STAY IN lb <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Pompano Beach</b> 42-3	
3. NAME OF DECEASED (Type or print) <b>First Mary Ann Lynn</b>		4. DATE OF DEATH <b>July 5 1966</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1921</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Lollie M. Kirkland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mae Nell Levy, Pompano Beach, Florida</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH 4201 45 minute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank M. Anderson</i> M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
22. DATE SIGNED <b>7-7-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>July 11, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Westview Community Cem.</b>
23d. LOCATION (City or Town) <b>Pompano Beach, Florida</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>John Trampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>Home Trampton Jr.</b>	
25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09696

## CERTIFICATE OF DEATH

09695

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>	c. LENGTH OF STAY IN 1b <b>7 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b> 12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Concord</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles</b>	First	Middle	Last
4. DATE OF DEATH <b>July 7 1966</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29, 1900</b>
9. AGE (in years last birthday) <b>65 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Yard</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>218-18-0258</b>	17. INFORMANT <b>Leonard P. Monath, Denton, Maryland, RFD</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate with</b> 177x <b>generalized metastasis</b> DUE TO <b>generalized metastasis</b> <b>7 months</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-29-65, 19</b> to <b>7-7-66, 19</b> , that (I) (we) last saw the deceased alive on <b>7-7-66 19</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank M. Anderson</i>	22b. DATE SIGNED <b>7-8-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>F. M. Anderson M.D.</b>	22d. ADDRESS <b>Federalsburg, Md. 21632</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Junior Order Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Preston, Maryland</b>
34. FUNERAL DIRECTOR <i>John Frampton and Son, Federalsburg, Maryland</i>	ADDRESS <i>None</i>	25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

- 1 -

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09697

09696

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 1. PLACE OF DEATH

a. COUNTY

CAROLINE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

DENTON

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

JOSEPHINE

First

Middle

PINE

Last

DATE  
OF  
DEATH

Month

JULY

Day

12 1966

## 5. SEX

F

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

JAN 3 1903

9. AGE (in years  
last birthday)

63 yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SECRETARY

## 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DELAWARE

## 12. CITIZEN OF WHAT COUNTRY?

WIA

## 13. FATHER'S NAME

THOMAS E. HUDSON

## 14. MOTHER'S MAIDEN NAME

MACIE S. MEREDITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give year or dates of service)

## 16. SOCIAL SECURITY NO.

17. INFORMANT

## Address

GERALD M. PINE, DENTON

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: Massive Cerebral embolism  
IMMEDIATE CAUSE (a)

331X

## DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

## (b)

Cerebral arterial spasms

## DUE TO

(c) Generalized arteriosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH  
Minutes

3 yrs

5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19 p.m.20d. INJURY OCCURRED  
While Not While  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL  
SIGNATURE

Jane B. Brumner

M.D. ASSISTANT MEDICAL EXAMINER EXAMINER'S  
NAME (Type)

Arnold R. P. Summer M.D.

M.D. DEPUTY MEDICAL EXAMINER DATE SIGNED  
7/7/66

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF July 14, 1966

22c. NAME OF CEMETERY OR CREMATORIUM DENTON

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS J.W. GRIFFIN MODER DENTON MD

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE JUL 20 1966 Charles Judge

VR A15ME  
5M 1/62



**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages V and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09698

1

1. PLACE OF DEATH  
a. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Greensboro

c. LENGTH OF STAY IN 1b

63 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

None

3. NAME OF  
DECEASED  
(Type or print)

First  
Arthur

Middle  
John

Last  
Urry

4. DATE  
OF  
DEATH  
7- 26 19 66

5. SEX

Male

6. COLOR OR RACE  
White

7. MARRIED  
WIDOWED

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH  
June 19, 1903

9. AGE (in years  
last birthday)  
63 yrs.

IF UNDER 1 YEAR  
Months Days Hours Min.  
USA

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME

John C. Urry

14. MOTHER'S MAIDEN NAME

Augusta Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-01-7095

17. INFORMANT

Mary Urry Greensboro, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

150X

Cancer of the stomach and lower

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

DUE TO

(b)

DUE TO

(c)

end of esophagus with regional  
metastasis and obstruction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1966, to July 26, 1966, that (I) (we) last saw the deceased alive on July 26, 1966, and that death occurred at 1:30 PM, from the causes and on the date stated above.

22b. DATE SIGNED

July 28 '66

22a. SIGNATURE

Charles H. Stonesifer  
22c. PHYSICIAN'S  
NAME (Type)

M.D. ATTENDING  
PHYS.

MED.  
DIRECTOR  STAFF  
PHYS.

22d. ADDRESS  
Charles H. Stonesifer, M.D. Greensboro, Md. 21639

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL  
LOCATION (City, town or county) (State)

Burial

7-29-66

Greensboro  
ADDRESS

Greensboro, Maryland

24. FUNERAL DIRECTOR

J. E. Boulais & Sons, Inc., Greensboro, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE AUG 1 1966 Charles Judge

1980

million

billion

million

of dollars

of dollars

one

such

yearly total

total

in billions of dollars

in billions of dollars

and

increased

income - more than twice as much

income - one billion dollars 2000-1980

or

more than twice the amount  
income - the amount in the  
period of 1980-1980

income - more than twice as much

income - one billion dollars 2000-1980

income - one billion dollars 2000-1980

or

income - one billion dollars 2000-1980

income - one billion dollars 2000-1980

or

income - one billion dollars 2000-1980

income - one billion dollars 2000-1980

or

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03693

## CERTIFICATE OF DEATH

09698

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>65 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>206 Buena Vista Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katie Andrew Wrightson</b>		First <b>Katie</b>	Middle <b>Andrew</b>
4. DATE OF DEATH July 17 1966	Last <b>Wrightson</b>	Month <b>July</b>	Day <b>17</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1892</b>
9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Andrew, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Andrew</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>216-05-3232</b>	17. INFORMANT <b>William W. Wrightson, Federalsburg, Maryland</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-1-65</b> , 19 <b>66</b> , to <b>7-17-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-17-66</b> , 19 <b>66</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>7-18-66</b>	
22a. SIGNATURE <i>Frank M. Anderson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Federalsburg, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Anderson</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
		23b. DATE THEREOF <b>July 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Hill Crest Cemetery</b>
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son, Federalsburg, Maryland</i>		25a. REC'D BY REGISTRAR <i>John Frumpton Jr.</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE <b>JUL 22 1966</b>	

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